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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SEANA A. TALBOT** **P.O. Box 242** **Ventura, CA 93002** **Registered Nurse License No. 637881** Respondent.	Case No. 2013-223 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about May 27, 2004, the Board of Registered Nursing issued Registered Nurse License Number 637881 to Seana A. Talbot (Respondent). The Registered Nurse License was in

full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2014, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 118, subdivision (b), of the Business and Professions Code ("Code") provides that the suspension, expiration, surrender or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

5. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it. . . ."

7. Section 2762 states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed

physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

8. Section 2764 provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b), the Board may renew an expired license at any time within eight (8) years after the expiration.

REGULATORY PROVISION

9. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

COST RECOVERY

10. Section 125.3 provides, in pertinent part:

(a) the Board may request the administrative law judge to direct a licentiate found to

have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

...

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

CONTROLLED SUBSTANCES / DANGEROUS DRUGS

11. **Demerol** is a Scheduled II controlled substance pursuant to Health and Safety Code section 11055. Demerol is a brand name for **Meperdine Hydrochloride**. It is a narcotic analgesic indicated for the relief of moderate to severe pain.

12. **Fentanyl** is a Scheduled II controlled substance pursuant to Health and Safety Code section 11055. **Fentora and Duragesic** are brand names for Fentanyl. It is a potent narcotic used for chronic pain such as cancer patients who require continuous pain relief.

13. **Morphine** is a Scheduled II controlled substance pursuant to Health and Safety Code section 11055. **MS Contin and Roxanol** are brand names for Morphine. It is a narcotic analgesic indicated for the relief of severe pain.

14. **Dilaudid** is a Scheduled II controlled substance pursuant to Health and Safety Code section 11055. Dilaudid is a brand name for **Hydromorphone**. It is a narcotic analgesic indicated for the relief of severe pain.

15. **Ativan** is a Scheduled IV controlled substance pursuant to Health and Safety Code section 11057. Ativan is a brand name for **Lorazepam**. It is a benzodiazepine used for the relief of anxiety, panic attacks, and chronic sleeplessness.

FIRST CAUSE FOR DISCIPLINE

(False Records)

16. Respondent is subject to disciplinary action under section 2761, subdivision (a), and 2762, subdivision (e), on the grounds of unprofessional conduct, in that on or about December 9, 2009, through January 6, 2010, while on duty as a registered nurse at Community Memorial Hospital (CMH), Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in the hospital, patient, or other record pertaining to controlled substances

for patients, as follows:

a. On or about January of 2010, CMH's Pharmacy Unit conducted a routine controlled substance audit of CMH's nursing staff. The audit revealed that the Respondent routinely withdrew large quantities of controlled substance from CMH's Pyxis[1] system for six (6) of her assigned CMH patients. Respondent's withdrawals exceeded the average of withdrawals that other registered nurses in the Respondent's Post Anesthesia Care Unit had withdrawn, who were also responsible for these patients' post-operative pain management care.

b. Patient # M00665001

1) On or about December 9, 2009, at 23:18 p.m., Respondent withdrew one hundred (100) mcg[2] of Fentanyl from Pyxis and failed to document administration and/or wastage of the one hundred (100) mcg of Fentanyl on the patient's Post Anesthesia Care (PAC) record. Respondent withdrew Fentanyl on December 9, 2009, at 23:18 p.m., however, the patient was discharged from the Post Anesthesia Care Unit at 20:30 p.m., approximately three (3) hours earlier.

2) **Respondent failed to account for the one hundred (100) mcg of Fentanyl** in the CMH record.

3) On or about December 9, 2009, at 23:18 p.m., Respondent withdrew ten (10) mg of Morphine from Pyxis and failed to document administration and/or wastage of the ten (10) mg of Morphine on the patient's PAC record. Respondent withdrew the ten (10) mg of Morphine on December 9, 2009, at 23:18 p.m., however, the patient was discharged from the Post Anesthesia Care Unit at 20:30 p.m., approximately three (3) hours earlier.

4) **Respondent failed to account for the ten (10) mg of Morphine** in the CMH record.

5) On or about December 9, 2009, at 18:55 p.m., Respondent withdrew ten (10) mg of

[1] The Pyxis is a medication dispensing machine used in hospitals. The pharmacy, usually within the hospital, will fill and maintain the medications in the machine and when a nurse or other qualified member needs a certain medication, they can log into the computer connected with the block of small drawers and get the med they need. When the nurse needs, say Lidocain, they log in and the computer causes the drawer that has Lidocain in it to open, she takes what she needs and closes the drawer. Usually once a day the pharmacy will check the computer against what is actually in the drawer and refill as needed. discrepancies are common.

[2] mcg (microgram)

Morphine from Pyxis. On December 9, 2009, Respondent documented administration of two (2) mg of Morphine, at 18:50 p.m., two (2) mg of Morphine, at 18:55 p.m., two (2) mg of Morphine, at 19:00 p.m., two (2) mg of Morphine, at 19:05 p.m., two (2) mg of Morphine, at 19:10 p.m., two (2) mg of Morphine, at 19:25 p.m., and two (2) mg of Morphine, at 19:35 p.m., for a total of fourteen (14) mg of Morphine, on the patient's PAC records. Therefore, Respondent withdrew ten (10) mg of Morphine from Pyxis, however, she documented administration of fourteen (14) mg of Morphine, an additional four (4) mg.

6) **Respondent failed to account for the additional four (4) mg of Morphine** in the CMH record.

c. **Patient # M00641130**

1) On or about December 10, 2009, at 17:10 p.m., Respondent withdrew ten (10) mg of Morphine from Pyxis. On December 10, 2009, Respondent documented administration of four (4) mg of Morphine, at 16:45 p.m., four (4) mg of Morphine, at 16:55 p.m., five (5) mg of Morphine, at 17:00 p.m., four (4) mg of Morphine, at 17:20 p.m. Therefore, Respondent withdrew ten (10) mg of Morphine on December 10, 2009 at 17:00 p.m., from Pyxis, however, she documented administration of eight (8) mg of Morphine to the patient prior to obtaining it from Pixis at 17:00 p.m. Further, Respondent withdrew ten (10) mg of Morphine, however, she documented administration of seventeen (17) mg of Morphine.

2) **Respondent failed to account for the additional seven (7) mg of Morphine** in the CMH record.

3) On or about December 10, 2009, at 17:31 p.m., Respondent withdrew ten (10) mg of Morphine from Pyxis and failed to document administration and/or wastage of the ten (10) mg of Morphine on the patient's PAC record.

4) **Respondent failed to account for the ten (10) mg of Morphine** in the CMH record.

5) On or about December 10, 2009, at 16:14 p.m., Respondent withdrew two (2) mg of Dilaudid from Pyxis. On December 10, 2009, Respondent documented administration of one (1) mg of Dilaudid, at 16:12 p.m., one (1) mg of Dilaudid, at 16:16 p.m., one (1) mg of Dilaudid, at 16:30 p.m., one (1) mg of Dilaudid, at 16:35 p.m. Therefore, Respondent withdrew two (2) mg of

Dilaudid on December 10, 2009 at 16:14 p.m., from Pyxis, however, she documented administration of four (4) mg of Dilaudid.

6) **Respondent failed to account for the additional two (2) mg of Dilaudid in the CMH record.**

7) On or about December 10, 2009, at 16:42 p.m., Respondent withdrew two (2) mg of Dilaudid from Pyxis and failed to document administration and/or wastage of the two (2) mg of Morphine on the patient's PAC record.

8) **Respondent failed to account for the two (2) mg of Dilaudid in the CMH record.**

d. **Patient # M00665179**

1) On or about December 11, 2009, at 20:12 p.m., Respondent wasted ten (10) mg of Morphine, however, there is no evidence that ten (10) mg of Morphine was previously withdrawn from Pyxis for this patient on that day.

2) **Respondent failed to account how and when the ten (10) mg of Morphine was previously withdrawn from Pyxis for this patient on that day.**

3) On or about December 11, 2009, at 23:07 p.m., Respondent withdrew **ten (10) mg** of Morphine from Pyxis and documented wastage of **nine (9) mg** of Morphine.

4) **Respondent failed to account for one (1) mg of Morphine in the CMH record.**

e. **Patient # M00667346**

1) On or about December 17, 2009, at 19:36 p.m., Respondent withdrew two (2) mg of Dilaudid from Pyxis. On December 17, 2009, Respondent documented administration of 0.2 mg of Dilaudid, at 19:40 p.m., 0.2 mg of Dilaudid, at 19:45 p.m., 0.2 mg of Dilaudid, at 19:50 p.m. Therefore, Respondent withdrew two (2) mg of Dilaudid, however, she documented administration of 0.6 mg of Dilaudid.

2) **Respondent failed to account for 1.4 mg of Dilaudid in the CMH record.**

3) On or about December 17, 2009, at 19:52 p.m., Respondent withdrew two (2) mg of Dilaudid from Pyxis. On December 17, 2009, Respondent documented administration of 0.2 mg of Dilaudid, at 19:55 p.m., 0.2 mg of Dilaudid, at 20:00 p.m., 0.2 mg of Dilaudid, at 20:05 p.m., 0.2 mg of Dilaudid, at 20:10 p.m., 0.2 mg of Dilaudid, at 20:15 p.m., 0.2 mg of Dilaudid, at 20:20

p.m., 0.2 mg of Dilaudid, at 20:25 p.m. Therefore, Respondent withdrew two (2) mg of Dilaudid, however, she documented administration of 1.4 mg of Dilaudid.

4) **Respondent failed to account for 0.6 mg of Dilaudid in the CMH record.**

5) On or about December 17, 2009, at 20:21 p.m., Respondent withdrew fifty (50) mg of Demerol from Pyxis. On December 17, 2009, Respondent documented administration of twenty five (25) mg of Demerol at 20:30 p.m. Therefore, Respondent withdrew fifty (50) mg of Demerol, however, she documented administration of twenty five (25) mg of Demerol.

6) **Respondent failed to account for twenty five (25) mg of Demerol in the CMH record.**

f. **Patient # M00029824**

1) On or about December 17, 2009, at 19:37 p.m., Respondent withdrew ten (10) mg of Morphine from Pyxis and failed to document administration and/or wastage of the ten (10) mg of Morphine on the patient's PAC record.

2) **Respondent failed to account for ten (10) mg of Morphine in the CMH record.**

g. **Patient # M00408508**

1) On or about January 6, 2010, at 1:38 a.m., Respondent withdrew two (2) mg of Ativan from Pyxis. On January 6, 2010, Respondent documented administration of one (1) mg of Ativan at 1:50 a.m. Therefore, Respondent withdrew two (2) mg of Ativan, however, she documented administration of one (1) mg of Ativan.

2) **Respondent failed to account for one (1) mg of Ativan in the CMH record.**

SECOND CAUSE FOR DISCIPLINE

(Illegally Obtain/Possess Controlled Substances / Dangerous Drugs)

17. Respondent is subject to disciplinary action under sections 2761, subdivision (a), and 2762, subdivision (a), on the grounds of unprofessional conduct, in that on or between December 9, 2009, through January 6, 2010, while on duty as a registered nurse at CMH, Respondent obtained or possessed in violation of law controlled substances and dangerous drugs. Complaint refers to and by this reference incorporates the allegations set forth above in paragraph 16, inclusive, as though set forth fully.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

18. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that while employed as a registered nurse at CMH, Respondent demonstrated acts of gross negligence, an extreme departure of repeated acts, as follows:

1) Respondent failed to provide nursing care that ensures no harm to come to one's patients due to failure to properly assess, treat, and/or withhold pain medications without cause and/or for personal reasons.

2) Respondent obtained and / or possessed controlled substances in violation of law.

Complaint refers to and by this reference incorporates the allegations set forth above in paragraphs 16-17, inclusive, as though set forth fully.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 637881, issued to Seana A. Talbot

2. Ordering Seana A. Talbot to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: SEPTEMBER 27, 2012

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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